Associates in Cardiovascular Disease

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE
AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Privacy Practice Notice

I have received a copy of the Associates in Cardiovascular Disease's Notice of Privacy Practices. I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Associates in Cardiovascular Disease, LLC for purposes of treatment, payment or healthcare operations. I understand that my protected health information may be used for such purposes without my written authorization.

_____ _____
Print Patient's Name **Date of Birth**

_____ _____
Signature of Patient/Parent/Guardian **Date**

Email address: _____

☐ **Check here if you do not wish voice messages to be left on your answering machine or voicemail.**

Day time phone number:_____

Emergency Contact number:_____

II. Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Associates in Cardiovascular Disease (AICD) may disclose certain documents regarding my health information to a family member, close personal friend or other caregiver because such a person is involved with my health care.

I designate the person(s) listed below as individual(s) involved with my health care provided by AICD for the purpose of making the disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request to AICD.

Print Name:_____ Relationship:_____Date of Birth:_____

Print Name:_____ Relationship:_____Date of Birth:_____

Print Name:_____ Relationship:_____Date of Birth:_____

_____ _____
Signature of Patient/Parent/Guardian **Date**